CHILD FAMILY CENTER
MILLVILLE PUBLIC SCHOOLS

2014-15
REGISTRATION INFORMATION

Please have the following to register your child:

- ❒ Birth Certificate
- ❒ Immunization Record
- ❒ Physical
- ❒ Proof of Residency
- ❒ Parent/Guardian ID
- ❒ Completed Enrollment Form
- ❒ Food Stamp Number (if applies)

Your child will not be placed until each of these has been submitted.

MILLVILLE PUBLIC SCHOOLS

STUDENT ENROLLMENT FORM

Today's Date: _____

Student's Last Name _____ First Name _____ Middle _____
Address _____ City _____ State ___ Zip _____ Phone [___] _____
Birth Date ____/____/____ Sex ❑ Male ❑ Female Ethnicity/Race _____
MM DD YY
City of Birth _____ State _____ Country _____
Date of US Entry ____/____/____ [Only applies to students NOT born in US]
MM DD YY

Has student ever attended Millville Schools? ❑ Yes ❑ No [If YES, last grade completed _____]

Father/Guardian Last Name _____ First Name _____ Suffix _____
Mother/Guardian Last Name _____ First Name _____
Student resides with: ❑ Both parents ❑ Mother only ❑ Father only ❑ Guardian ❑ Custody/Restrictions

Father cell phone [____] _____
Father work phone [____] _____

Mother cell phone [____] _____
Mother work phone [____] _____

Are parents federally employed? ❑ Yes ❑ No Federal ID# _____

Non-Household Emergency Contacts
Contact #1 _____ Relationship to student _____ Phone [____] _____
Contact #2 _____ Relationship to student _____ Phone [____] _____
Contact #3 _____ Relationship to student _____ Phone [____] _____

Last school attended _____ Phone [____] _____
School address _____ Fax [____] _____
City _____ State _____ Zip _____

Siblings Name _____ DOB ____/____/____ School attending _____ Grade ____
Siblings Name _____ DOB ____/____/____ School attending _____ Grade ____
Siblings Name _____ DOB ____/____/____ School attending _____ Grade ____

Check all that apply
❑ Classified Student ❑ Basic Skills Required ❑ Attended Alternative School ❑ 504 or Medical Alert
❑ Home Instruction ❑ Requires Bilingual ❑ Another Language Spoken Language _____

SCHOOL USE ONLY

School assigned to _____
Start date _____
Entered by _____
Transportation _____

Grade _____
Student ID # _____
State ID # _____

❑ Health Record ❑ Proof of Residency ❑ BC/Transfer Card
❑ MEETS REQUIREMENTS

Faxed to _____ by _____

CHILD FAMILY CENTER
JoAnn D. Burns, Principal
1100 Coombs Road
Millville, N. J. 08332
Phone: (856) 293-2171
Fax: (856) 293-2174
Email: joann.burns@millvillenj.gov

Dear Parent/Guardian,

Thank you for your cooperation in setting up a preschool/kindergarten registration visit for your child. Please fill out the information below:

PK 3 Year Olds_____ PK 4 Year Olds_____ Kindergarten_____

Child's Name_____ Date of Birth____/____/____

Address_____

Telephone No._____

Parent/Guardian Name_____

Present School Attending_____

A physical is a requirement to attend school. We will have a nurse practitioner available during registration free of charge. Please check below if you are interested in an appointment for your child with the nurse practitioner. The County Health Department will be available for lead screening.

_____ yes, please set up an appointment _____ yes, I would like the lead screening

_____ no, I am not interested in an appointment _____ no, I am not interested in the lead screening

Our registration dates will be Tuesday and Wednesday, August 19 and 20, 2014. Please check the date that you prefer and we will make every attempt to schedule you on that date. You will be notified by mail of your appointment date and time.

_____ Tuesday, August 19, 2014, 3:00 PM – 7:00 PM

_____ Wednesday, August 20, 2014, 9:00 AM – 1:00 PM

DO NOT WRITE BELOW THIS LINE

Preschool/Kindergarten Registration

Your appointment is:

Child's Name_____

Date_____ **Time**_____

Location: **Child Family Center**
1100 Coombs Road (Wheaton Village)
Millville, N. J. 08332

☐ **YOUR CHILD WILL NOT NEED TO ATTEND.**

CHILD FAMILY CENTER
JoAnn D. Burns, Principal
1100 Coombs Road
Millville, N. J. 08332
Phone: (856) 293-2171
Fax: (856) 293-2174
Email: joann.burns@millvillenj.gov

THREE YEAR OLD PROGRAM

Child's Name _____ Birthdate_____
Parent's Name _____
Address _____
Phone Number _____

The following providers are available for you to choose to send your three year old child. Please visit and select which you would prefer to have your child attend. Number your first three choices 1, 2 and 3.

☐	Corson Park Day Care 4 North 12th Street 825-5540 – Jill Miller	Abbott Hours Wrap Hours	9:00 AM – 3:00 PM 6:30 AM – 5:30 PM
☐	Millville Day Care Center 911 Columbia Avenue 825-5345 -- Danielle Schmidt	Abbott Hours Wrap Hours	8:30 AM – 2:30 PM 6:45 AM – 5:30 PM
☐	Rieck Avenue Country Day School 250 Rieck Avenue 825-9067 -- Ellen Dayton/Jennifer Ellis	Abbott Hours Wrap Hours	9:00 AM – 3:00 PM 6:30 AM – 5:30 PM
☐	Millville Head Start 532 N. High Street 327-1665 -- Amanda Sheets	Abbott Hours	9:00 AM – 3:00 PM
☐	Child Family Center 1100 Coombs Road 293-2171 – Clara Beatty	Abbott Hours Wrap Hours	8:00 AM – 2:00 PM 7:00 AM – 5:30 PM

Please return this form with your selections and comments and all other registration information to me at the Child Family Center.

No child can be assigned a slot in a center until **all** registration requirements (birth certificate, proof of residency and health records) have been submitted to the Child Family Center.

Thank you,

JoAnn D. Burns
Principal

REQUIRED IMMUNIZATIONS

NEEDED FOR

PRE-SCHOOL 3 & 4 YEAR OLDS

DTaP - 4 DATES

POLIO - 3 DATES

MMR - 1 DATE AFTER 1ST BIRTHDAY

HIB - 1 DATE AFTER 1ST BIRTHDAY

PCV - 1 DATE AFTER 1ST BIRTHDAY

VARIVAX - 1 DATE AFTER 1ST BIRTHDAY

OR WRITTEN PROOF OF CHICKEN POX DISEASE

FLU BETWEEN 9/1 & 12/31 EACH YEAR

HEALTH HISTORY

PHYSICAL EXAM BY DOCTOR

OR NURSE PRACTITIONER

ALL RECORDS MUST BE SIGNED BY PHYSICIAN

RECOMMENDED IMMUNIZATIONS

HEPATITIS B SERIES

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last) (First)	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

CHILD FAMILY CENTER
Nurse Health Registration Form

Dear Parent Guardian:

The school nurse's office is open from 8:00 am to 5:00 pm daily. The health services provided for all students are: Height, Weight, Dental, Hearing, Vision and Blood Pressure Screenings.

The non-prescription medications which are available to all students with approval of the school physician are: Chloraseptic throat spray, Anbesol, Vaseline, Sting Kill, 0.5% hydrocortisone ointment, eye wash, sterile saline, Polysporin ointment and burn gel.

If your child requires prescription or non-prescription medication on a regular basis, you must obtain a written order from your child's physician on the school medication administration form and you will need to supply the medication and sign the form giving the school nurse permission to give the medication.

Please complete the questionnaire on the back and return it to the school nurse so we can update your child's health records. This information will be shared with your child's teacher, administration, and other staff on a need to know basis unless a written note is received from you requesting it be kept confidential.

If you have any questions regarding the health services provided, please call us at 856-293-2178.2177. We look forward to this school year and hope we can be of help to you and your child.

Sincerely,

Karen Chamenko, RN, BA, CSN
Jeanne Reed, RN, BSN

MILLVILLE PUBLIC SCHOOLS

STUDENT HEALTH HISTORY

STUDENT NAME: _____ _____
Last First

Nickname: _____ **Gender:** F / M **Birthdate:** ___/___/___ Grade: _____
(circle one)

Language spoken in Home: _____ Name of Interpreter: _____

Does your child wear glasses? ☐ Yes ☐ No **Contacts?** ☐ Yes ☐ No **Orthodontic appliance?** ☐ Yes ☐ No
Does your child currently receive: Speech Therapy ☐ Yes ☐ No Physical Therapy ☐ Yes ☐ No Occupational Therapy ☐ Yes ☐ No

Doctor Name: _____ **Phone:** _____
Dentist Name: _____ **Phone:** _____

Does your child have an allergy to any foods, medications, insects, latex or other substances? ☐ **Yes** ☐ **No**
If Yes, please list in detail: _____
Please circle if allergy is **severe moderate mild** List symptoms: _____
What medication(s) or treatment is used to treat the allergy? _____
Has your child ever had a severe "anaphylactic" reaction requiring emergency care (list date)? _____

Please check all that apply to your child:

- ☐ Allergies – seasonal
- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Chicken Pox- Date: _____
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Dyslexia/Learning disorder
- ☐ Eating disorder
- ☐ Epilepsy/Seizure Disorder
- ☐ Heart Condition
- ☐ Hearing Problems
- ☐ Kidney Disorder
- ☐ Migraine Headache
- ☐ Muscular/Orthopedic Disorder
- ☐ Pervasive Developmental Disorder
- ☐ Psychiatric/Psychological Disorder
- ☐ Serious Accident
- ☐ Surgery
- ☐ Vision Problems
- ☐ Other: _____

If yes to any of the above, describe and indicate any restrictions:
_____
_____

If your child is on medication, please list medication, dosage, frequency and reason for medication:
_____
_____

Please note any health concerns of which the school nurse needs to be aware: _____
_____
_____

Other information to be shared with the School Nurse: _____
_____

☐ Yes ☐ No I give the School Nurse permission to share health information with school personnel on a "need to know" basis in writing and/or verbally.

For Preschool Only (3yr &4yr old students)

☐ Yes ☐ No I give permission for my child to receive acetaminophen as ordered by the school physician and administered by the School Nurse for fever above 101 degrees if the parent/guardian cannot be reached.

Signature of Parent or Guardian: _____ **Date:** _____

Reviewed by Certified School Nurse: _____ Date: _____

Rev. 3/13

BLOOD LEAD SCREENING FORM

To be completed by the Parents/Guardians

Child's Information:

Name:_____ Birth Date:_____

Address:_____

_____

Telephone Number: (___) _____

Parent's/Guardian's Name: _____

Child Care Center Information:

Name:_____ Address:_____

Telephone Number: (___) _____ _____

To be completed by the Child's Health Care Provider

Health Care Provider's Information:

Name:_____

Address:_____

_____

Telephone Number: (___)_____

Blood Lead Screening(s)

Date	Age	Comments

Health Care Provider's Signature:_____ Date:_____

Parents/Guardians: Please return this completed form to your Child Care Center